DSS-EA-240 11/03

APPLICATION FOR LONG TERM CARE OR RELATED MEDICAL ASSISTANCE

Instructions to the Person Applying for Assistance

Please read all questions carefully before filling out this form and any attached supplements. This information will be used in determining your eligibility and need for assistance. All questions on the form must be completed. If you need help completing or understanding this form, or obtaining social security numbers, contact the Department of Social Service in the county where you live. The form and attachments, when completed and signed by the applicant or authorized representative and witnessed as indicated, should be returned to your local Social Service Office. **All information must be verified. Please attach copies of all verifications.**

For Office Use Only

Case Number Assigned

ID# Assigned

Date received in local office:

This application is for:

Long Term Care Assistance _____ **Assisted Living** _____ **Adult Foster Care** _____ **Other** _____

1. **Personal Information** (Please Print)

A. Your Name: _____
(First) (Middle) (Last)

B. Current Address: _____
(Nursing Home, Hospital, etc.) (Street) (City) (Zip) (County)

Home Address: _____
(Street) (City) (Zip) (County)

Home Telephone Number (_____) _____–_____

* Completion of race, social security numbers (SSN) and citizenship is optional for person not requesting assistance.

C. Race (can check more than one)
( ) White
( ) American Indian
( ) Black
( ) Hawaiian
( ) Asian

D. Ethnicity
Also check here if Hispanic
( )

E. Date of most recent admission to a medical facility, hospital, or nursing home. Month _____ Day _____ Year _____

F. How many months have you or someone else paid private rate for your continuous care in any facility? _____ months

G. Sex
Male ( )
Female ( )

H. Birthdate
Month _____ Day _____ Year _____

I. Marital Status
( ) Married ( ) Divorced
( ) Single ( ) Widowed

J. Are you a resident of South Dakota? Yes ( ) No ( )
Have you applied for or received assistance from South Dakota in the past? Yes ( ) No ( )
If yes, in what county? _____

K. Social Security Number

L. Medicare Claim Number

M. Civil Service Annuity Number

N. Railroad Retirement Number

O. Veterans Benefit Number
Name of Veteran

P. Do you have Medicare
Part A? Yes ( ) No ( )
Part B? Yes ( ) No ( )

2. **Spouse** (If ever married, please answer the questions below) A. Full Name of Spouse _____ Address of Spouse _____ _____		B. Birthdate Month _____ Day _____ Year _____ C. If deceased, date of death. Month _____ Day _____ Year _____
D. Social Security Number	E. Medicare Claim Number	F. Civil Service Annuity Number
G. Railroad Retirement Number	H. Is/was your spouse a Veteran Yes ( ) No ( )	I. Veterans Benefit Number

3. **Dependents**

A. If you have dependent children living in your home, complete the questions below.

Child's Name	Date of Birth	Social Security Number

B. Dependent's Gross Income:	Source_____ Amount_____ Frequency_____	Source _____ Amount _____ Frequency _____

4. Living Arrangements

A. Do you or your spouse have shelter costs? (House payments, rent, utilities, etc.) Yes ( ) No ( )
If yes, specify type and amount of expenses below. All shelter costs must be verified.

Type of Expense	Amount of Payment	Other
Mortgage	$	Balance due:
Taxes	$	How often paid?
Insurance	$	How often paid?
Rent	$	How often paid?
Utilities [ ] Heating [ ] Electricity [ ] Air Conditioning	 $ _____ $ _____ $ _____	

B. Does anyone pay food or shelter costs for you or give you money to pay these costs? Yes ( ) No ( )
If yes, specify type of expenses and amount paid below.

Type of Expense	Amount of Payment	Who Pays
	$	
	$	

5. **Medical**

A. Name and address of your primary physician.

_____

_____

_____

B. Have you visited your doctor or have you been hospitalized during the last three months?

Yes ( ) No ( )

Name & address of hospital

_____

_____

C. Are you requesting retroactive assistance for any of the last three months? Yes ( ) No ( )

If yes, for what months?

_____

_____

_____

6. **Authorized Representative**

A. If you are completing this form for another person give:

Your Full Name (Print) _____

Address _____

_____

Telephone (_____)_____

Your Title or Relationship to Applicant _____

B. Name & address of applicant's relative or friend who may be contacted for information:

_____

_____

Telephone (_____)_____

7. **Legal Guardian/Power of Attorney**

Do you have a legal (court-appointed) guardian? Yes ( ) No ( )

Do you have a Power of Attorney? Yes ( ) No ( )

Name and address of this person _____

_____

_____

Their telephone Number_____

Date of guardianship of Power of Attorney (Month & Year) _____

Please provide a copy of document unless previously provided.

8. **Resources/Assets**

Complete questions below for yourself and your spouse. (Include all your resources/assets, and those owned by your spouse or owned jointly with anyone.)

(NOTE: YOU ARE REQUIRED TO VERIFY ALL OF THE FOLLOWING INFORMATION)

A. **Cash on hand, savings at home, or money held by friends/relatives** Yes ( ) No ( )

Description:	Owner(s):	Value: $

B. **Do you have money in a nursing home account?** Yes ( ) No ( )

Current Balance:

C. **Do you or your spouse have checking accounts or money market accounts?** Yes ( ) No ( )

Bank Name:	Owner(s):	Current Balance: $ $ $ $	Account Number: 1. 2. 3. 4. Does checking acct. pay interest? Yes ( ) No ( )

NOTE: You are required to attach copies of your most recent bank statements

D. **Do you or your spouse have savings accounts?** Yes ( ) No ( )

Bank Name:	Owner(s):	Balance: $ $ $ $	Account Number: 1. 2. 3. 4.

E. **Do you or your spouse have certificates of deposit?** Yes ( ) No ( )

Bank Name:	Owner(s):	Current Value: $ $ $ $	Certificate #: 1. 2. 3. When is interest Paid? ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

F. **Do you or your spouse own U.S. bonds?** Yes ( ) No ( )

Description:	Owner(s):	Total Value:	Series# Purch. Date: ____ _____ ____ _____ ____ _____ ____ _____

G. **Do you or your spouse have funds such as Keogh, or IRA's?** Yes ( ) No ( )			
Describe:	Owner(s):	Total Value: $ $ $	Name & Address of Institution
H. **Do you or your spouse have funds in an annuity or any similar plan or legal instrument?** Yes ( ) No ( )			
Describe:	Owner(s):	Total Value: $	Date of Purchase:
I. **Are you or your spouse named in any trust?** Yes ( ) No ( )			
Describe:	Owner(s):	Total Value: $	Name of Trustee:
J. **Do you or your spouse have municipal/corporate/government bonds?** Yes ( ) No ( )			
Describe:	Owner(s):	Total Value: $	Name & Address of Institution
K. **Do you or your spouse have stocks or mutual funds?** Yes ( ) No ( )			
Describe:	Owner(s):	Total Value: $	Name & Address of Institution
L. **Do you or your spouse have a safety deposit box?** Yes ( ) No ( )			
Location:	Owner(s):	List Contents:	
M. **Do you or your spouse own a home?** Yes ( ) No ( )			
Location:	Owner(s):	Who lives in the home Amount owned on home? $_____	
N. **Do you or your spouse own real property (land, city lots, etc.)?** Yes ( ) No ( )			
Is this property rented? Yes ( ) No ( )	Owner(s):	Value: $	County Located:
O. **Do you or your spouse own any buildings or property rights (including mineral or timber rights)?** Yes ( ) No ( )			
Where? (County & State)	Owner(s):	Value: $	Description:

P. **Do you or your spouse retain a life estate in any property?** Yes ( ) No ( )

Owner(s) of property	County Location:	Property Value: $	Legal Description:

Q. **Do you or your spouse have real property held in trust by the U.S. Government (ie: lease land)?** Yes ( ) No ( )

Tribe of Enrollment: County:	Enrollment Number:	Yearly Lease Income: $	IIM Account No.:

R. **Do you or your spouse own business equipment, machinery, livestock, antiques, or collections other than household furnishings?** Yes ( ) No ( )

Please List	Value:
_____	$
_____	$
_____	$
_____	$
_____	$
_____	$

S. **Have you or your spouse sold property on a contract for deed?** Yes ( ) No ( )

Balance Due on Contract: $_____	Owner(s) of property:	Description of Property:

T. **Do you or your spouse have ownership in licensed or unlicensed cars, trucks, motorcycles, boats, recreational vehicles (camper, snowmobile), or any other vehicle?** Yes ( ) No ( ) If yes complete below.

Owner's First and Last Name:	Co-owner's First and Last Name:	Amount Owed:
Year, Type, Make Model of Vehicle::	What is Vehicle used for	Value: $
Owner's First and Last Name:	Co-owner's First and Last Name:	Amount Owed:
Year, Type, Make Model of Vehicle::	What is Vehicle used for	Value: $

U. **Do you or your spouse have life insurance policies?** Yes ( ) No ( )
If yes, list all policies:

Policy No.	Name of Company	Address	Policy Owner	Face Value	Cash Value

V. **Do you or your spouse have any financial arrangements such as contracts, insurance, or accounts designated for burial?** Yes ( ) No ( ) **If yes, list below.**

Applicant	Spouse
Where?_____	Where? _____
_____	_____
Face Value_____	Face Value_____
Does the interest stay in this account? Yes ( ) No ( ) If no, is the interest paid to you? Yes ( ) No ( )	Does the interest stay in this account? Yes ( ) No ( ) If no, is the interest paid to you? Yes ( ) No ( )

9. **Property/Assets In Trust Or Transferred**

A. In the last thirty-six months have you, your spouse, or anyone on behalf of you or your spouse, transferred, given away, loaned, or deeded sole or joint ownership in anything of value, such as money, land buildings, etc.?
Yes ( ) No ( ) If yes, complete below.

1. Item transferred, given away, loaned, or deeded: _____
   Date of transactions(s): (Month & Year) _____
   Cash Value at time of transfer: _____
   What did you receive in return:_____
   _____

2. Item transferred, given away, loaned, or deeded: _____
   Date of transactions(s): (Month & Year) _____
   Cash Value at time of transfer: _____
   What did you receive in return:_____
   _____

3. Item transferred, given away, loaned, or deeded: _____
   Date of transactions(s): (Month & Year) _____
   Cash Value at time of transfer: _____
   What did you receive in return:_____
   _____

B. **In the last thirty-six months have you, your spouse, or anyone established a joint ownership in any real property owned by either you or your spouse?** Yes ( ) No ( ) If yes, complete below.

1. Date of Joint Ownership: _____ Type of property:_____
   Name of Joint Owner:_____ Address of Joint Owner: _____

2. Date of Joint Ownership: _____ Type of property:_____
   Name of Joint Owner:_____ Address of Joint Owner: _____

C. **In the last thirty-six months has a joint owner taken possession of their share in any of your or your spouse's assets, such as money, savings accounts, checking accounts, certificates of deposits, bonds, stocks, or anything else of value?** Yes ( ) No ( ) If yes, complete below.

1. Date joint owner took possession of their share: Month _____ Day _____ Year _____
   List the type of asset: _____
   Name of joint owner: _____Address of joint owner: _____

2. Date joint owner took possession of their share: Month _____ Day _____ Year _____
   List the type of asset: _____
   Name of joint owner: _____Address of joint owner: _____

D. **In the last sixty months were any of your, your spouse's funds, or property placed in trust for you, your spouse, or anyone else?**
Yes ( ) No ( ) If yes, complete following:

1. Date Established: _____ Value: _____
   Name of Trustee:_____ Address of Trustee: _____

2. Date Established: _____ Value: _____
   Name of Trustee:_____ Address of Trustee: _____

E. **In the last thirty-six months has any payment from a trust (either income or principal) become unavailable to you or your spouse?** Yes ( ) No ( ) If yes, complete the following:

Date payment stopped or ceased to be available: Month _____ Day _____ Year _____
Name of Trustee:_____Address of Trustee:_____

F. **Is any of your income paid directly into a trust?** Yes ( ) No ( ) If yes, complete below:

Date trust was established. Month _____ Day _____ Year _____
Name of Trustee:_____Address of Trustee:_____

10. **Health Insurance/Nursing Home Insurance**

A. **Do you or your spouse have any health insurance coverage**? Yes ( ) No ( )
If yes, complete below for each person insured.

Insurance Company Name & Address	Policy Number	Type of Coverage	Premium Amount
_____ _____ _____	_____	☐ Inpatient Hospital ☐ Outpatient ☐ Dental ☐ Cancer ☐ Medicare Supplement ☐ Other (i.e. prescriptions, Workman's Compensations _____ _____ _____	Paid: $ _____ ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually Employer Name (if have group insurance) _____
Name of Insured _____ Policy Holder Name _____	Group Number _____ Policy Began ___/___/___		
Insurance Company Name & Address	Policy Number	Type of Coverage	Premium Amount
_____ _____ _____	_____	☐ Inpatient Hospital ☐ Outpatient ☐ Dental ☐ Cancer ☐ Medicare Supplement ☐ Other (i.e. prescriptions, Workman's Compensations _____ _____ _____	Paid: $ _____ ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually Employer Name (if have group insurance) _____
Name of Insured _____ Policy Holder Name _____	Group Number _____ Policy Began ___/___/___		

B. **Do you or your spouse have any Nursing Home Insurance**? Yes ( ) No ( )
If yes, complete below for each person insured.

Company & Address	Policy #	Person Insured	Premium Amount
_____ _____ _____	_____ _____		Paid: $_____ ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually
_____ _____ _____	_____ _____		Paid: $_____ ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually
_____ _____ _____	_____ _____		Paid: $_____ ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

10. **Income** (List all income and benefits that you or your spouse receive from any source.)

Please provide proof of all income received.		List amount of income. If not received monthly, indicate how often.	
		You	Your Spouse
A. Actual amount of your Social Security Check	Yes ( ) No ( )		
B. SSI (Supplemental Security Income)	Yes ( ) No ( )		
C. Veterans Benefits	Yes ( ) No ( )		
D. Veterans Compensation	Yes ( ) No ( )		
E. Railroad Retirement	Yes ( ) No ( )		
F. Civil Service Annuity	Yes ( ) No ( )		
G. Other Pension If yes, list name, address, & acct #. _____ _____	Yes ( ) No ( )		
H. Annuities	Yes ( ) No ( )		
I. Trusts	Yes ( ) No ( )		
J. Insurance Payments	Yes ( ) No ( )		
K. IRA/KEOGH Payments	Yes ( ) No ( )		
L. Interest Income (on bonds, bank acct's, CD's etc.)	Yes ( ) No ( )		
M. Lease Income	Yes ( ) No ( )		
N. Rental Income	Yes ( ) No ( )		
O. BIA General Assistance	Yes ( ) No ( )		
P. Payments on Contract for Deed	Yes ( ) No ( )		
Q. Contributions from Relatives or Others	Yes ( ) No ( )		
R. Gross Earnings from Employment	Yes ( ) No ( )		
S. Child Support Payments	Yes ( ) No ( )		
T. Alimony Payments	Yes ( ) No ( )		
U. Income from Mineral or Timber Rights	Yes ( ) No ( )		
V. Income from Life Estate	Yes ( ) No ( )		
W. Any Other Income	Yes ( ) No ( )		

12. **Certification of Citizenship or Alien Status**

The Immigration Reform and Control Act (Public Law 99-603), as amended by the Personal Responsibility and Work Opportuity Reconciliation Act of 1996, requires every person applying for Food Stamps, TANF, or Medical Assistance to provide a declaration of citizenship or alien status. Any person who refuses or chooses not to provide information about their citizenship or alien status will not be eligible for benefits, however the individual may be required to answer questions and submit verifications about his or her income/recourses, etc. The individual's information may affect the eligibility and/or benefit level of the household. EXCEPTION: Emergency medical assistance may be available regardless of citizenship, immigration status, or having a Social Security Number.

Proof of United States citizenship must be provided for each individual applying for Food Stamps, TANF, or Medical Assistance if citizenship is questionable. Non-citizens applying for or receiving benefits will need to show documentation of immigration status from the Immigration and Naturalization Service (INS). This proof will be verified by the Department of Social Services through INS. Information received from INS may affect your household's eligibility and level of benefits.

For all members required to state their citizenship or alien status, an adult household member (18 years of age and over) must sign below certifying each member's U.S. citizenship or alien(s) in satisfactory immigration status.

Under penalty of perjury, I certify by signing my name below that I am and members of my household are United States citizens or aliens in satisfactory immigration status:

List Names of Applicants	Status*	Signature	Date

*List status of each person such as: Citizen, Lawful Alien, Student, Visa, etc.

ASSIGNMENT OF MEDICAL SUPPORT, INSURANCE PROCEEDS

An application for and acceptance of medical assistance paid from the Department of Social Services shall operate as an assignment and subrogation of any rights to medical support, insurance proceeds, or both that the applicant or recipient may have. Any rights or amounts so assigned or subrogated shall be applied against the cost of the applicant's or recipient's care

ESTATE RECOVERY AND MEDICAL ASSISTANCE LIENS

Under Federal and State law, the Department of Social Services is authorized to make recovery from the estates of deceased medical assistance recipients, who were permanently institutionalized or who were at least 55 years of age and for whom the Department made a payment for nursing facility services; intermediate care facility services for the mentally retarded; other medical institutional services, home and community based services; hospital services; and prescription drug services. The Department of Social Services is authorized to recover the debt of a medical assistance recipient from the estate of a surviving spouse. If a surviving spouse wishes to limit the amount of the surviving spouse's estate that will be liable for recovery for the amount of medical assistance paid on behalf of the recipient, the surviving spouse must file a petition within six months of the death of the medical assistance recipient. The petition will determine the amount of the surviving spouse's estate from which recovery may be claimed for Medicaid expended on behalf of the applicant indicated below. The petition must be filed on the Department's form.

Under Federal and State law, the Department of Social Services may impose a medical assistance lien against real property owned by a recipient who has received a benefit from the Department of Social Services for the services of a nursing facility, an intermediate care facility for the mentally retarded, or other medical institution. The Department of Social Services will issue a separate notice when the Department decides to impose a lien. The notice will describe the amount of the lien and the real property to which the lien is to attach.

Under State law, the Department of Social Services is authorized to recover any funds of the resident kept or maintained by the home or other facility if the resident was receiving medical assistance from the Department at the time of death.

Privacy Act Statement

Federal and State Law Regulations limit the use and disclosure of confidential information concerning applicants and recipients of economic and medical assistance programs to purposes directly related to the administration of those programs. When you apply for assistance from the Department of Social Services, you will be asked to provide your Social Security Number on the application

form. Title 42 of the Code of Federal Regulations Part 435.910(a), requires the furnishing of Social Security Numbers as a condition of eligibility for Medicaid. The Department uses your number in its computer processing for eligibility determination, welfare fraud investigations and audits. Social Security Numbers are also used to verify income information, through agencies such as Internal Revenue Service, Department of Labor, and Social Security Administration, etc. to prevent a person or family from receiving duplicate benefits under any program, to make mass changes in benefits easier to implement and to determine the accuracy and reliability of information given to the department by applicants for and recipients of assistance.

Verifications

Information you give to answer the questions on this form, and information obtained by the department to verify your answers will be used to determine your eligibility and level of benefits. Your benefits may change from month to month, or be stopped, based on this information.

Federal and state officials will verify information given on this form to determine if it is correct. A department representative may contact you or may contact other people in order to verify your eligibility for assistance. Information given will also be verified by computer cross-matching with other agencies and private sectors. When state and federal personnel verify the information on this application, if what is reported is found to be incorrect your Medical case may be denied or terminated and you may be subject to criminal prosecution for knowingly providing false information.

Authorization to Furnish Information and Release Information

I hereby authorize any person, agency or institution to supply information requested by the Department of Social Services concerning me or my family, and to allow inspection and reproduction of records in his or their possession pertaining to me or my family by any duly authorized representative of the Department. I further authorize the Department to release such information to providers or cooperating State or Federal Agencies.

This authorization is given only in connection with its use by the Department in the administration of its programs and for no other purpose. It shall continue in effect until such time as I state in writing that it is no longer valid.

I herewith release any person, agency or institution from any and all liability to me or my family for supplying such information.

Civil Rights Guarantee

The provisions of the Civil Rights Act of 1964, as amended, also apply to your case and department representatives shall not, on the grounds of race, color, creed, religion, sex, disability, ancestry, or national origin, exclude you from participation in, deny the benefits of, or otherwise subject you to discrimination under any program or activity administered by the department. Any person who feels that his civil rights have been violated may request a fair hearing. You may also file a complaint of discrimination by writing BOP/DSS, ATTN: HRM, 445 East Capitol, Pierre, SD 57501 or by calling (605) 773-6941.

Acknowledgement

I understand that any false statements which I may make and any failure on my part to report any change in circumstance which would affect my eligibility for payment from programs administered by the South Dakota Department of Social Services constitutes a crime and that I could be prosecuted under South Dakota criminal laws.

I agree to provide information upon request from the Department of Social Services concerning any asset or estate which may be subject to recovery, estate recovery, or medical assistance liens by the State of South Dakota.

SIGNATURES

Applicant should sign the application unless incapacitated or represented by a Legal (Court Appointed) Guardian. An authorized representative may sign the application on behalf of the incapacitated or deceased applicant. The applicant's mark should be witnessed by a person familiar with the applicant.

Signature of Applicant or Recipient	Date	Signature of Spouse	Date
Witness to Applicant's mark	Date	Signature of Authorized Representative, Legal Guardian or Power of Attorney	Date
Signature of Caseworker	Date		